11900 CRITERIA FOR ADMINISTRATIVE ADJUSTMENT ACTIONS

For In-State Hospitals and Major Border Status Hospitals

Requests for an administrative adjustment may be submitted by hospitals for one or more of the following specific circumstances or occurrences.

A. Correction of Inappropriate Calculation of Rates

Qualifying Determination: One or more components of the payment rate schedule must have been inappropriately calculated under the rate setting plan. An inappropriate calculation is:

(1) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
(2) A clerical error in calculating a component of the hospital's payment rate schedule, or
(3) Incorrect or incomplete application by the Department of provisions of the rate setting methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment rate schedule.

(Note that the rate setting methodology and standards are specified in attachment 4.19A of the State Plan.)

Request Due Date and Effective Date: The 60 day rule applies per §11600 above. For rate calculation corrections initiated by the Department, the 60 day rule does not apply if data is corrected which has not been audited by the Department or by an agent of the Department for the Wisconsin Medical Assistance Program. Any resulting corrected rates may be retroactively effective to the original effective date of the rate being corrected.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital must supply data or information to the Department to support an adjustment. The data must be able to be audited currently or at a later time by the Department. An audited cost report of the hospital may need to be reopened in order to resolve the adjustment request.

Reopening Audited Cost Report: Either the hospital or the Department may request that the Medicaid audit contractor reopen an audited cost report. An audited cost report may be reopened only if all of the following conditions are satisfied: (1) the dollar effect is $5,000 or greater, (2) the statistic affecting the payment rate is in error by 5% or more, and (3) the request for reopening and the necessary data is submitted to the audit contractor within five years from the end date of the cost reporting period for which the cost report is being reopened. The audit contractor will apply these conditions.

The Department may request that the audit contractor obtain additional data or perform additional audit tests when reopening a cost report. The audit contractor's charge to the Department for reopening a cost report may be billed to the provider if it was the provider's error that was in need of correction.

Legal Review Pursued by Hospital: Corrections of payment rate calculations must be pursued by a hospital through this administrative adjustment before the hospital can pursue legal review of its rate calculation. If a hospital does pursue any available legal review after requesting an administrative adjustment, the Department will withdraw any proposed rate adjustment as to any given issue it has offered to the hospital, and the Department will not put the adjusted payment rate into effect. If the adjusted payment has been put into effect and is an increase over the payment previoulsy in effect, the adjusted payment will be retroactively rescinded to the date it was effective and replaced with the payment in effect prior to the adjustment. In such a case, increased payments at the adjusted rate will be recovered by the Department.

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TN # New Page

B. Use More Current Cost Report If Available Cost Report Is More Than Three Years Old

A hospital's audited cost report which is on file with the Department is the basis for determining: (1) the disproportionate share adjustment under §5243, (2) capital payment under §5400, (3) direct medical education payment under §5500. (4) the cost to charge ratio for outlier payments under §5300, and (5), for hospitals in Wisconsin, the rural hospital adjustment under §5260. For the indirect medical education adjustment under §5230, the audited cost report or information provided by the hospital's Medicare intermediary from the period of an audited cost report is used.

If any of the payment components are based on an audited cost report period which is more than three years old, this administrative adjustment allows an adjustment of all of the above payment factors based on a more current audited cost reporting period. All factors requiring cost report data will be adjusted with no option by the hospital or the Department to elect to adjust only some of the payment factors. The reimbursement a hospital receives may increase or decrease as a result of using the more current cost report data.

Qualifying Determination: The end date of the period of the audited cost report used by the Department for establishing any component of a hospital's specific payment rate precedes the effective date of the payment rate by more than three years and three months.

For example, for a hospital's payment rates effective July 1, 1994, the Department used the hospital's audited cost report for its fiscal year ended December 31, 1990. Back-up 3 months from July 1, 1994 to April 1, 1994 and then subtract 3 years from 1994 resulting in a date of April 1, 1991. The hospital would qualify because its cost report used for establishing payment rates ended before April 1, 1991.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted payments are effective. A rate year ends each June 30th. (See §11500 above for more detail.)

Definition, Updating Fiscal Year: The *updating fiscal year* is the first fiscal year of the hospital which ended on or after date three years and three months prior to the effective date of the payment rates.

For example, a hospital has a fiscal year ending September 30. The hospital's rate effective July 1, 1994 was based on its September 30, 1990 fiscal year cost report. Its updating fiscal year would be its fiscal year, which ended September 30, 1991. (The reference date was calculated by backing-up 3 months from July 1, 1994, to April 1, 1994 and then subtracting 3 years from 1994.)

Interim Adjustment: The audited cost report for the updating fiscal year may not be available at the time a hospital requests this administrative adjustment. The Department may provide interim adjusted payment amounts until the cost report is available. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that the interim adjustment is a reasonable and reliable estimate of the final expected capital and direct medical education payment rates, the disproportionate share adjustment, the outlier cost to charge ratio, the rural adjustment and the indirect medical education adjustment..

Final Adjustment: After the Department receives an audited Medicaid cost report for the updating fiscal year, all four payment factors will be calculated and adjusted based on the audited data, specifically: (1) the disproportionate share adjustment, (2) the capital payment, (3) the direct medical education payment, (4) the hospital's cost to charge ratio for outlier payments, (5) the rural adjustment, and (6) the indirect medical education adjustment. The payment amounts will be determined according to the rate setting methodology that was in effect for the period for which the final adjusted payment amounts are to be effective. A recoupment or payout will be made for the period for which the final adjusted payment factors apply.

Adjustment for Inflation: A table of the inflation rate multipliers which are to be used for interim and final adjustments of capital and direct medical education payments effective in a specific rate year are listed in Appendix 27200.

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C.1 Capital Payment Adjustment for Major Capitalized Expenditures, Effective January 1, 1996

This administrative adjustment provides for an updating of a hospital's capital payment. It provides a means through which a hospital can have its capital payment adjusted to recognize recent major expenditures that improve, add to, or replace existing equipment and structures that are directly or indirectly used for inpatient services. The following criteria apply to capital payment rates in effect for inpatient services with dates of discharge on and after January 1, 1996.

Qualifying Determination: A hospital qualifies for this adjustment if the hospital's total capitalized depreciable assets at the *end* of the hospital's updating fiscal year have increased by an amount that is 25% or greater of total capitalized depreciable assets at the *beginning* of the base cost report period. Qualification will be determined by comparing the amount of capitalized depreciable assets reported in the hospital's audited financial statements for the respective comparison dates. If audited financial statements are not available to determine qualification, the hospital can request this adjustment and an interim adjustment will be provided pending completion of audited financial statements. Interim adjustments are described below.

Request Due Date and Effective Date: The 60-day rule applies per §11600 above. However, requests delivered by June 30, 1996 may be effective January 1, 1996 at the request of the hospital.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30. (Reference: §11500)

Definitions

Rate year. A *rate year* is the twelve months July 1 through June 30 (also defined in §3000)

Capitalized depreciable assets. *Capitalized depreciable assets* include depreciable land improvements, buildings, fixed equipment and moveable equipment owned by the hospital and such assets leased by the hospital through capitalized leases and excludes capitalized construction-in-progress.

Base fiscal year cost report. The *base fiscal year cost report* is the audited Medicaid cost report used to calculate the capital payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests a capital payment adjustment due to the use of a cost report being more than three years old (adjustment B), then the updating cost report, which is used for the old cost report adjustment, will be the base cost report for this adjustment.

Audited financial statements. The *audited financial statements* of the hospital are its independently audited financial statements with a statement of audit scope and opinion by a certified public accountant.

Updating fiscal year cost report. For adjustments effective on and after January 1, 1996, the *updating fiscal year cost report* is the Medicaid cost report for the fiscal year that ended in the rate year in which the payment adjustment is effective. For example, a hospital's fiscal year ends December 31. The hospital requested a capital adjustment effective July 1, 1996. The updating cost report for that capital adjustment will be its cost report for its fiscal year ending December 31, 1996. For the next year the hospital requested and received a capital adjustment July 1, 1997 for the same capital project. For that adjustment, the updating cost report will be from its fiscal year ending December 31, 1997.

Interim Adjustment: The Department may provide an interim adjusted capital payment rate until a final adjustment can be calculated. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final expected capital payment rate.

Final Adjustment: After the Department receives an audited Medicaid cost report for the updating fiscal year, a retroactive adjustment will be calculated based on the audited data and a recoupment or payout will be made for the period for which the interim capital payment was made. The final adjusted rates will be determined according to §5400 of the rate setting methodology in effect for the period for which the final adjusted payment is to be effective. A table of the inflation rate multipliers, which are to be used for final adjustments effective in a specific rate year, are listed in Appendix 27200.

Special Provision for Adjustment Effective July to December 1995: Any hospital that requested and received an adjustment effective in July through December 1995 will have two final settlements calculated for the rate year July 1995 through June 1996. One final adjustment will be calculated according to item C.2 for July through December 1995 and a second final adjustment will be calculated according to this item C.1 for January through June 1996.

Next Page is 43.1.b

TN # 97-013 JUN 0 4 1998 Page 43.1.a
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C.2 Capital Payment Adjustment for Major Capitalized Expenditures Effective July 1, 1993 through December 31, 1995

This administrative adjustment provides for an updating of a hospital's capital payment rate. It provides a means through which a hospital can have its capital payment adjusted to recognize recent major expenditures which improve, add to, or replace existing equipment and structures which are directly or indirectly used for inpatient services. The following criteria apply to any adjustment which is to be effective on or after July 1, 1993 through December 31, 1995.

Qualifying Determination: The hospital's total capitalized depreciable assets at the end of the hospital's updating fiscal year have increased by an amount which is 25% of total capitalized depreciable assets at the beginning of the period of the base cost report. The hospital will elect the updating fiscal year according to the definition below. Qualification shall be determined by comparing the amount of capitalized depreciable assets reported in the hospital's audited financial statements for the respective comparison dates.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Definitions

Capitalized depreciable assets include depreciable land improvements, buildings, fixed equipment and moveable equipment which are owned by the hospital and such assets leased by the hospital through capitalized leases and excludes capitalized construction-in-progress.

The *base cost report* is the audited Medicaid cost report which was used to calculate the capital payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests a capital payment adjustment due to the use of a cost report being more than three years old, then the updating cost report which is used for the old cost report adjustment will be the base cost report for this adjustment.

The *updating cost report* is the Medicaid cost report for a fiscal year of the hospital which ended between the end date of the base cost report period and three months prior the effective date of the capital payment rate for which an adjustment is being requested.

For example, a hospital's fiscal year ends in August. Its capital payment effective July 1, 1993 was based on a cost report period which ended August 31, 1990. The updating cost report period can be for any fiscal year ending after August 31, 1990 and prior to April 1, 1993. (April, May and June 1993 are the three months preceding the effective date of the capital payment to be adjusted.)

The *audited financial statements* of the hospital are its independently audited financial statements with a statement of audit scope and opinion by a certified public accountant.

Interim Adjustment: The Department may provide an interim adjusted capital payment rate until a final adjustment can be calculated. Upon consultation with the Department, the hospital must provide the Department sufficient information in order that the interim adjustment is a reasonable and reliable estimate of the final expected capital payment rate.

Final Adjustment: After the Department receives an audited Medicaid cost report for the updating fiscal year, a retroactive adjustment will be calculated based on the audited data and a recoupment or payout will be made for the period for which the interim capital payment was made. The final adjusted rates will be determined according to §5400 of the rate setting methodology which was in effect for the period for which the final adjusted payment is to be effective.

Adjustment for Inflation: A table of the inflation rate multipliers which are to be used for interim and final adjustments effective in a specific rate year are listed in Appendix 27200.

D.1 Adjustment for Changes in Medical Education, Effective July 1, 1999, hospitals not located in Wisconsin may not receive an administrative adjustment under this section.

This administrative adjustment provides for an updating of a hospital's medical education payment and its payment for the indirect expense of its medical education program. It provides a means through which a hospital's starting, significantly altering or ending a medical education program may be recognized. The following criteria apply to medical education payment rates in effect for inpatient services with dates of discharge on and after January 1, 1996. The payment for the indirect cost of a medical education program, as determined under §5230, will be also be adjusted. That is, both direct and indirect medical education payments will be adjusted.

Qualifying Determination: A hospital's rate of payment for its direct and indirect expense of a medical education program may be adjusted in a rate year upon a significant change in its direct medical education expenses. To determine if a change is significant for a hospital: (1) its total direct medical education expenses from the updating fiscal year will be inflated to the rate year in which the adjustment is effective, (2) its total direct medical education expenses from its base fiscal year will be inflated to the rate year in which the adjustment is effective, and (3) the difference, item 1 minus item 2, divided by the inflated base year amount, item 2,must be at least 10% to qualify as a significant change for this adjustment. A table of the inflation rate multipliers that are to be used for adjustments effective in a specific rate year are listed in Appendix 27200. If a cost report does not cover a year, the expense will be annualized.

Request Due Date and Effective Date: The 60-day rule applies per §11600 above. However, requests delivered by June 30, 1996 may be effective January 1, 1996 at the hospital's request.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30. (Reference §11500.)

Definitions

Rate year. A *rate year* is the twelve months July 1 through June 30 (also defined in §3000)

Base fiscal year cost report. The *base fiscal year cost report* is the Medicaid cost report used to calculate the direct medical education payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests an adjustment due to the use of a cost report being more than three years old (adjustment B), then the updating cost report, which is used for the old cost report adjustment, will be the base cost report for this adjustment.

Updating fiscal year cost report. For adjustments effective on and after January 1, 1996, the *updating fiscal year cost report* is the Medicaid cost report for the fiscal year that ended in the rate year in which the adjustment is effective. For example, a hospital's fiscal year ends December 31. The hospital requested an adjustment effective July 1, 1996. The updating cost report for the final adjustment (described below) will be its cost report for its December 31, 1996 ending fiscal year.

Interim Adjustment: The Department may provide an interim adjusted medical education payment until a final adjustment can be calculated. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final expected medical education payment.

The information provided by the hospital to the Department may not sufficiently show that the hospital does or will qualify for an adjustment. Under such a circumstance, the Department will deterimine qualification and an interim payment when sufficient data is available or when the final adjustment can be completed, whichever comes first.

Final Adjustment: After the Department receives an audited Medicaid cost report for the updating fiscal year, a retroactive adjustment will be calculated based on the audited data and a recoupment or payout will be made for the period for which the interim payment adjustments were provided for direct and indirect medical education expenses. The adjusted final rate of payment will be allowed or denied by application of the above qualification standard. If allowed, the final adjusted rates will be determined according to the rate setting methodology in effect for the period for which the final adjusted payments are to be effective. The direct medical education payment rate will be determined according to §5500. The indirect medical education rate of payment will be determined according to §5230. A table of the inflation rate multipliers, which are to be used for final adjustments effective in a specific rate year, are listed in Appendix 27200. Recoupment from or payments to the hospital will be made to reconcile actual payments to the final adjusted rate for the period for which the final rate of payment applies.

Special Provision for Adjustment Effective July to December 1995: Any hospital that requested and received an adjustment effective in July through December 1995 will have two final settlements calculated for the rate year July 1995 through June 1996. One final adjustment will be calculated according to item C.2 for July through December 1995 and a second final adjustment will be calculated according to this item C.1 for January through June 1996.

D.2 Adjustment for Changes in Medical Education Effective July 1, 1993 through December 31, 1995

This administrative adjustment provides for an updating of a hospital's payment rates for the direct and indirect expense of its graduate medical education (GME) program. It provides a means through which a hospital's termination, starting or significantly altering a GME program may be recognized. The following criteria apply to any adjustment which is to be effective on or after July 1, 1993 through December 31, 1995.

Qualifying Determination: A hospital's rate of payment for its direct and indirect expense of a graduate medical education (GME) program may be adjusted if the hospital's total direct GME expense from its updating cost report, adjusted for inflation, has increase or decreased by an amount that is at least 10% of the total direct GME expense, adjusted for inflation, from its base cost report.

The totals of direct GME expense will be adjusted for inflation, as described below, before applying the 10% standard. Direct GME expense totals will also be adjusted to an annual amount, if any of the cost reports are not for an annual period, by dividing the GME expense amount which is not an annual amount by the number of months covered by the respective cost report period and multiplying the result by twelve.

The above criteria applies to a hospital requested adjustment and to a Department initiated adjustment. The fiscal year of the updating cost report is to be elected by the hospital if the hospital makes the adjustment request or by the Department if it initiates the adjustment.

Request Due Date and Effective Date: The 60 day rule of §11600 above applies.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Definitions

The *base cost report* is the Medicaid cost report which was used to calculate the direct graduate medical education (GME) rate of payment for which an administrative adjustment is requested. If this adjustment is requested and the hospital also requests a direct GME payment adjustment due to the use of a cost report being more than three years old, then the updating cost report which is used for the old cost report adjustment will be the base cost report for this adjustment.

The *updating cost report* is the Medicaid cost report for a fiscal year of the hospital which ended after the end date of the base cost report period and before the three months prior to the effective date of the payment rate for which an adjustment is being requested or initiated.

For example, a hospital has a fiscal year ending in August. Its GME payment effective July 1, 1993 was based on a cost report period which ended August 31, 1990. The updating cost report period can be for any fiscal year ending after August 31, 1990 and prior to April 1, 1993. (April, May and June 1993 are the three months preceding the effective date of the GME payment.)

Interim Adjustment: An unaudited updating cost report will be used to calculate interim adjusted direct and indirect rates of payment if an audited Medicaid cost report is not available for the updating cost period. The interim adjustment will be allowed or denied by application of the above qualifying standard. If allowed, the direct payment will be determined according to §5500. The interim indirect payment will be determined according to §5230. If an interim adjustment is allowed, the Department will initiate a final adjustment when the audited updating cost report is available. The Department may adjust the data provided in an unaudited cost report.

If an interim adjustment is denied, a final adjustment may be allowed if the hospital qualifies for the adjustment based on a subsequently available audited cost report for the updating cost report period. The hospital must initiate the final adjustment in this circumstance. The hospital must deliver a written request to the Department to reconsider its request for the direct GME adjustment which had been previously denied. The written request must be delivered within 5 years after the end date of the updating cost report period. The Department may

Continuation -- Changes in Medical Education

extend this due date if delays in the availability of the audited cost report prevented the hospital from meeting the 5 year deadline. The Department will only make an adjustment in the direct and indirect GME payment rates for the period for which the original denied request applied.

For example, a hospital requested a GME adjustment for the rate year July 1993 through June 1994. The Department denied the adjustment in 1993 based on the hospital's unaudited updating cost report for its fiscal year ended September 30, 1992. The audited cost report became available in January 1996. The hospital would qualify for a GME adjustment based on that audited cost report. The hospital has until September 30, 1997 to request the Department to reconsider making an adjustment to the hospital's GME payment rates in effect in the year July 1993 through June 1994.

Final Adjustment: The Department will determine final adjusted direct and indirect GME payment rates based on the audited updating cost report. The adjusted final rate of payment will be allowed or denied by application of the above qualification standard. If allowed, the final adjustment rates will be determined according to the rate setting methodology which was in effect for the period for which the final adjusted payments are to be effective. The final direct GME payment rate will be determined according to §5500. The final indirect GME rate of payment will be determined according to §5230 based on intern, resident and bed counts acquired from the hospital's Medicare intermediary for the period of the updating cost report, or, if not available from the intermediary, from the audited updating cost report.

If a final adjustment is allowed, then recoupment from or payments to the hospital will be made to reconcile actual payments to the final adjusted rate for the period for which the final rate of payment applies.

If a final adjustment is denied based on the audited cost report and an interim adjustment had been made, then recoupment from or payments to the hospital will be made to reconcile payments to the rate of payment which had been calculated from the base cost report.

Adjustment for Inflation: A table of the inflation rate multipliers which are to be used for interim and final adjustments effective in a specific rate year are listed in Appendix 27200.

F. Reclassification of Hospital to Different Wage Area

Requests for this adjustment are due by the April 30th date before the July 1 annual rate update.

The standard DRG group rate which is applicable to a hospital is adjusted by a wage area index pursuant to §5220. Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by HCFA in the Medicare program.

Qualifying Determination: If the Medicare Geographic Classification Review Board (MGCRB) has reclassified a hospital to a wage area, other than the area of its physical location, the hospital may, through this administrative adjustment, request the Department to recognize the reclassification for determining Wisconsin Medicaid rates. The hospital will have to submit documentation of the MGCRB reclassification decision to the Department.

A reclassification by the MGCRB which is effective for a federal fiscal year beginning on October 1 will be recognized by the Department for the Wisconsin Medicaid rate year beginning the preceding July 1.

The Department has divided the Medicare Milwaukee MSA into two wage areas, (1) a Milwaukee county only wage area, and (2) an Ozaukee-Washington-Waukesha counties' wage areas. The Department will not place any hospital, which was reclassified by Medicare to the Milwaukee MSA, into the Department's Milwaukee county only wage area. Such a hospital will be placed in the Department's Ozaukee-Washington-Waukesha county wage area.

Request Due Date and Effective Date: In order for a reclassification to be recognized in a specific rate year beginning July 1, a hospital must deliver its request for reclassification by April 30 prior to the beginning of that rate year. The Department may extend this due date if the hospital does not receive notice of a reclassification decision from the MGCRB before the April 15 date prior to the April 30 due date.

Continuation - Wage Area Reclassification

A hospital may withdraw a request for reclassification, which it had previously submitted, by delivering a written notice of its withdrawal to the Department by April 30 without regard as to whether or not the hospital has or will withdraw its reclassification in the Medicare program.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. A hospital's wage area reclassification will be granted for only one rate year. A new request must be submitted for any subsequent rate year. (Reference §11500 above.)

> For example, on March 26, 1993, a hospital received a notice from the MGCRB that it was reclassified for the federal fiscal year October 1, 1993 through September 30, 1994. The hospital must submit its request for a reclassification to the Department by April 30, 1993 in order for the reclassification to be recognized in the hospital's Medicaid rates effective July 1, 1993 through June 30, 1994. If in 1994 the hospital is again reclassified by the MGCRB, then it must submit a new reclassification request to the Department for its July 1994 through June 1995 Medicaid rates.

Adjustment Procedure: A hospital's wage area reclassification will be recognized in the calculation of wage area adjustment indices according to the method described in §5220.

G. Adjustment for Hospital Upon Approval by Medicare of an Exempt Psychiatric Unit

The Wisconsin Medicaid Program (WMAP) pays for psychiatric stays in general hospitals at differing DRG weighting factors depending on whether the hospital's psychiatric unit is or is not Medicare-exempt (reference §5150). This administrative adjustment allows a hospital which acquires Medicare exemption for a psychiatric unit to be paid at the DRG weighting factors for Medicare-exempt psychiatric units.

Qualifying Criteria: A general hospital must acquire Medicare exemption for its psychiatric unit and provide the Department a copy of the Medicare approved exemption.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above. The effective date cannot precede the effective date of the Medicare program's exemption.

Expiration of Adjustment: The adjustment will expire when Medicare withdraws, terminates or discontinues the exemption.

H. Adjustment for Hospitals With Psychiatric Units Which Are Not Medicare-Exempt

The Wisconsin Medicaid Program (WMAP) pays for psychiatric stays in general hospitals at differing DRG weighting factors depending on whether the hospital's psychiatric unit is or is not Medicare-exempt (reference §5150). This administrative adjustment may allow a hospital with an "is not" unit to be paid at the same DRG weighting factors as the WMAP pays hospitals with Medicare-exempt psychiatric units.

Qualifying Determination: A general hospital with a psychiatric unit which is not Medicare-exempt may request to be placed in the Medicare-exempt grouping for WMAP reimbursement if the hospital meets the conditions and criteria specified in Appendix §29000 of the State Plan.

Request Due Date and Effective Date: The 60 day rule applies per §11600 above.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.) A hospital must submit a new request each rate year.

Continuation -- Psychiatric Units, Not Medicare-Exempt

Adjustment Procedure: The requesting hospital must certify that it meets the conditions and criteria specified in Appendix §29000 of the State Plan. For this certification, the Department will provide an application form which must be completed and signed by the hospital. The Department will approve or deny the hospital's request. If approved, the hospital must maintain compliance with the conditions and criteria of Appendix §29000. Hospitals which, through on-site audits, surveys or other means, are found to not be in compliance will immediately lose their status in the Medicare-exempt grouping for Medicaid reimbursement. The Department may reinstate the hospital's status when the hospital achieves compliance.

I. Adjustment for PEI Ceasing to be Mandatory

Section 5160 provides that if the HMO/PEI ceases to be mandatory in Milwaukee County, the Department will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates.

Qualification Determination: If the HMO Preferred Enrollment Initiative (PEI) ceases to be mandatory in Milwaukee county, a hospital located in Milwaukee county may request continuation of an adverse selection adjustment to consider the remaining volume of voluntary PEI discharges.

Request Due Date and Effective Date: The 60 day rule per §11600 applies when a hospital is notified of its hospital-specific DRG base rate which is adjusted to eliminate the Milwaukee county-wide adverse selection adjustment.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. The hospital has to request this adjustment each rate year thereafter. (Reference §11500 above.)

Adjustment Procedure: The hospital will be eligible for an HMO adverse selection adjustment percentage in proportion to the remaining volume of PEI discharges but not exceeding the adverse selection adjustment percentage provided in §5160. The adjustment would be calculated by multiplying the adverse selection adjustment percentage provided in §5160 by the voluntary/mandatory ratio. The voluntary/mandatory ratio is the ratio of the number of PEI inpatient discharges in the first twelve months after the PEI went voluntary to the PEI inpatient discharges in the last twelve months before the initiative went voluntary . This adjustment will be calculated after auditable logs of PEI admissions are submitted to the Department for both twelve month periods.

Following is an example of the calculation. Hospital A had 1000 HMO/PEI discharges in the last year of the mandatory PEI program, and 100 HMO/PEI discharges in the first year the program went voluntary. The adverse selection adjustment percentage in §5160 is 10%.

Calculation: 1) 100 PEI cases divided by 1000 PEI cases = .1
2) .1 X 10% = .01 or 1%

Hospital A would receive a 1% HMO adverse selection adjustment.

J. **Administrative Adjustment for Professional Component, Not applicable after December 31, 1991.**

K. Eligibility for Rural Hospital Adjustment Considering Days Provided Under Out-of-State Medicaid Programs and/or Governmental Programs Other Than Medicare and Medicaid

Qualifying Determination: This administrative adjustment allows the inclusion of out-of-state Medicaid days and days associated with other government programs in determining eligibility for the rural hospital adjustment of §5260. A hospital may request this administrative adjustment if it would qualify for the rural hospital adjustment according to the criteria provided in §5260.1 but does not qualify solely because its combined Medicare and Medicaid utilization is less than 55%.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

Continuation -- Other Government Programs Considered in Rural Adjustment

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The inpatient days associated with hospital stays of (1) enrollees in Medicaid programs of states other than Wisconsin and (2) enrollees in other public assistance governmental health programs will be recognized in determining eligibility for the rural hospital adjustment of §5260. These inpatient days will be included in the numerator of the utilization rate, with Medicare and Medicaid inpatient days, for determining eligibility. If the resulting utilization rate equals or exceeds 55%, the hospital is eligible for a rural hospital adjustment. Data submitted by the hospital may be audited at a latter date and, if the data is found to in error, the Department will recover any overpayment that resulted from the erroneous data.

L. Adjustment to Rural Hospital Adjustment Percentage for Substantial Increase in Medicaid Utilization.

Qualifying Determination: A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5260.1 and had a current Medicaid utilization which is at least 25% greater than the Medicaid utilization on which the hospital's rural adjustment was determined.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital will need to furnish Medicaid inpatient days and total inpatient days from a current twelve month period which is acceptable to the Department. The inpatient days should exclude long-term care days from hospital swing-beds. The inpatient days may include the inpatient days of enrollees in Medicaid programs of states other than Wisconsin. The rural hospital adjustment percentage will be determined according to §5260.2 based on this new data. The data may be audited at a latter date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.

M. Adjustment to Rural Hospital Adjustment Percentage for Recognition of Out-of-State Medicaid Days

Qualifying Determination: A rural hospital may request this administrative adjustment to recognize inpatient days of enrollees of Medicaid programs other than the Wisconsin Medical Assistance Program (out-of-state Medicaid). A hospital may request this administrative adjustment if it qualifies for the rural hospital adjustment according to §5260.1.

Request Due Date and Effective Date: The 60 day rule per §11600 above applies.

Expiration of Adjustment: The adjustment expires at the end of the rate year in which the administratively adjusted rate is effective. A rate year ends each June 30th. (Reference §11500 above.)

Adjustment Procedure: The hospital will need to furnish out-of-state Medicaid inpatient days for the same reporting period of the Wisconsin Medicaid days which were used in establishing the rural hospital adjustment percentage. The rural hospital adjustment percentage will be determined based on a Medicare and Medicaid utilization rate which includes out-of-state Medicaid days. The data may be audited at a latter date and, if the data is found to be in error, the Department will recover any overpayment that result from the erroneous data.